Do We Really Need to Pay for Performance?

To the Editor:

Why should we pay more for a hospital to meet “best practice” performance standards as established by professional review organizations (as discussed in Karl Matuszewski’s editorial, “The New Pay-for-Performance Plans,” P&T, page 758, December 2003)? We all should know by now about beta-blocker use in myocardial infarctions and community-acquired pneumonia protocols to include blood cultures, flu shots in the fall, and pneumonia vaccinations. We should probably pay 2% less per condition when these practices are not being done in our institutions. I think you would get a lot more people interested from the outset in doing what “best practices” say we should be doing. This would make competition strictly come from within, the way it should be, rather than from the outside.

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Increased Pneumonia, Congestive Heart Failure Linked to Anti-TNF Agents?

To the Editor:

Thank you for Dr. Goldenberg’s clear and concise article in the January 2004 issue of P&T (“Advances in Treating Crohn’s Disease, Rheumatoid Arthritis, and Ankylosing Spondylitis: The ‘Dark Side’ of Anti-Tumor Necrosis Factor Therapy,” page 30). We in managed care are noticing an increased number of severe pneumonia/pulmonary/congestive heart failure admissions to local hospitals in patients that seem disproportionate to their pre-existing habitus and environment. You raise the question of possible prior usage of tumor necrosis factor (TNF) prescriptions (especially Enbrel® and Remicaid®) in such admissions as a comorbid factor based on undesirable secondary effects of the drugs. It is a good and interesting question and one that our medical plan (commercial HMO) will address.

We have too few enrollees to statistically determine the coincidence between lymphoma and initiation of TNF therapy; we will keep a watch for the possibility of even a few such cases.

Thank you for a thought-provoking review. We would hope for other such informative articles from Dr. Goldenberg in the future.

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